Ageing and Society, **17**, 1997, 447–460. Printed in the United Kingdom
© 1997 Cambridge University Press

Progress Report

Gerontological Nursing: Professional Priority or Eternal Cinderella?

MICHAEL NOLAN*

Introduction

Over thirty years ago geriatric nursing, as it was then called, was at the forefront of nursing research in the United Kingdom. Concurrent with the emergence of geriatric medicine as a distinct speciality, the pioneering study of Doreen Norton and colleagues (Norton *et al.* 1962) served to highlight both the deficits that existed in the hospital care of older people and the enormous potential of nursing to improve the situation, particularly for the 'irremediable' patient (Norton 1965). Caring for those who could not be cured but required on-going support was seen to constitute 'true nursing' and was identified as an area of practice in which nurses should excel (Norton 1965, Wells 1980). Such potential went largely unrealised, however, as nursing focused on acute, hospital-based care (Nolan 1994). As a consequence, those working in continuing care struggled to find value in their work and patients were subjected to 'aimless residual care' (Evers 1991), a situation exacerbated by the continued application of the biomedical model (Reed and Watson 1994). Despite claims that nurses working with older people have 'special skills' (Royal College of Nursing 1993), the nature of such skills has therefore never fully been explicated. Indeed, Armstrong-Esther *et al.* (1994) asked what nurses currently contribute to the well-being of elderly people and, following their study, suggested that nurses must take the initiative and expand their role if 'we are going to avoid simply warehousing the elderly until they die'. The need to act is particularly pressing at present as the spectre of 'bed-blockers' emerges once more and there is growing professional concern that older people may soon be denied the right to receive care from a qualified nurse (*Nursing Times* 1996).

* School of Nursing, University of Sheffield, Sheffield S5 7AU, UK.

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

The last few years have witnessed the gradual emergence of gerontological nursing in the United Kingdom (Nolan 1994, 1996, Wade and Waters 1996). This synthesises elements of gerontology, geriatrics and geriatric nursing (Rempusheski 1991, Wade 1996), thereby shifting the emphasis from a problem-focused, hospital-orientated approach towards a more holistic model which incorporates primary, secondary and tertiary interventions. These developments are attributable in part to the academic interest in this area of care which, whilst highlighting current deficits, suggests that nurses have a growing knowledge base upon which to draw (Nolan 1996). Although gerontological nursing fully acknowledges the needs of relatively independent older people, there is now a realisation that one of the greatest challenges lies in providing high quality care for chronically ill and disabled individuals and their family carers (Funk *et al.* 1993). Whilst the terminology may have changed, the opportunity therefore presents itself for nursing to take a lead role in caring for those with on-going needs. Central to debates in this area are the meaning, purpose and nursing role in rehabilitation (Sheppard 1994*a*, Nolan 1996), particularly the extent to which rehabilitation is either confined largely to the acute care episode or extends to include a longitudinal component that incorporates psycho-social as well as physical elements.

This article considers the rehabilitation of older people as currently practised in the United Kingdom as an exemplar for the health care of older people generally. It argues that rehabilitation as a whole, and the nursing role in particular, is constrained by the functional model of health prevalent within medicine (Wilkin and Hughes 1986). This, it is suggested, results in partial and incomplete care which fails to meet the needs of many older people and their family carers (Baker *et al.* 1997). It is contended that the tenets of gerontological nursing should be applied in order that a more sensitive, appropriate and comprehensive approach to rehabilitation can emerge. How this may be achieved and the barriers to success are considered briefly in the context of the close evolutionary paths followed by geriatric medicine and nursing.

Rehabilitation: what constitutes success?

In seeking to establish the principles underpinning rehabilitation, Mulley (1994) suggests that 'the concept, style and purposes of rehabilitation are changing'. He describes a shift away from the early

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

focus on younger people, many with war injuries, for whom the intention was to enable a return to work, towards older people for whom the aim is to achieve optimum levels of independence and well-being. Concurrently rehabilitation has become more than 'the province of therapists' intent on restoring function, for there is now a greater appreciation of the importance of preventing complications and of maintaining levels of improvement beyond hospital discharge. This more holistic approach is supposedly reflected in the importance now accorded to social and psychological aspects of the disabling process. Elaborating upon this basic thesis, Mulley (1994) described several key components of rehabilitation spanning the aims of care, the actions required, and the focus of attention. These included: listening, dignity, communicating, the environment, family supporters, compensating for disability and team-working. Whilst few would argue with these laudable attributes, they are not always attained. One study found that disabled people who wanted respect, understanding and to be involved in the process of rehabilitation, expressed the opinion that doctors and nurses were focused largely on the clinical elements of their role and neglected the emotional and psychological needs of the patients (Baker *et al.* 1997).

Following a major review of disability and rehabilitation services in the United Kingdom, Beardshaw (1988) highlighted the absence of an effective national system, a consequence of the failure to implement the recommendations of numerous reports spanning some 40 years. For example, the need to establish a distinct specialty of rehabilitation together with regionally based services. This situation has also been noted by others (Waters 1991, 1996). Beardshaw (1988) described the existing picture as bleak and identified major inadequacies in both primary and secondary care. The recent survey of the health care received by disabled people, alluded to above, suggests that little has improved in the last decade (Baker *et al.* 1977). Oliver argues that 'all is not well in the kingdom of rehabilitation' and he berates the 'physicality' of current practice whereby success is defined largely in terms of physical activity. This, he believes, denies the lived experience of many disabled people, and confined them to 'failures' of the system. Using conductive education as an illustration he states: 'if rehabilitation attempted to set a range of goals that was unachievable for most of its clientele, that in order to pursue the unachievable goals great stress was placed on family life, and that the physical was emphasised to the detriment of psychological health and social development, then it would be out of business quickly' (Oliver, 1993, p. 39).

The present onus on physical functioning as the primary criterion of

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

success is likely to be reinforced as the health service increasingly distances itself from continuing care and seeks clear-cut indicators as to when it has fulfilled its responsibilities. Given the demographic trends, a more holistic orientation towards rehabilitation is required and nursing has a significant role to play. However, to realise this potential requires considerable work if present entrenched attitudes are to be altered.

The nurse's role in rehabilitation: current accounts and perspectives

In considering the nurse's current role in rehabilitation, two main orientations are apparent; in one, rehabilitation is seen as integral to most nursing activity whereas in the other it is regarded as 'specialist' practice. Reflecting the former orientation, Waters (1991, 1996) argues that an element of rehabilitation can be discerned in a wide spectrum of nursing activity. More recently, however, rehabilitation nursing is being portrayed as a distinct area of care. Indicative of this is the publication of *Standards of Care for Rehabilitation Nursing* (Royal College of Nursing 1994). The main premise on which a specialist role is predicated is the need to shift the focus away from illness and disability towards health and wellness. An indication of just how difficult this may prove with respect to older people can be gathered from recent publications.

Probably the most comprehensive British study of the nurse's role in the rehabilitation of older people is that of Waters (1991, 1996, Waters and Luker 1996). She indicates that the majority of the rehabilitative effort is confined to a hospital setting and is focused mainly on physical care, the primary purpose being to return patients to a level of independence and discharge them to the community. Patients are largely passive recipients in this process and the needs of their carers are rarely considered until the point of discharge. The prime responsibility for rehabilitation is vested with therapists: the nurse's role, whilst not unimportant, is secondary and comprises three main components:

- 'General maintenance', including both the overall management of the ward and maintaining patients' physical well-being by attention to personal hygiene, nutrition, and skin care;
- 'Specialist', where the nurse is seen to have a degree of expertise, particularly in continence and skin care;
- 'Carry on', in which the nurse maintains the progress made by

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

therapists, especially in walking and dressing, throughout each 24 hours.

However, Waters (1991, 1996) identifies several problematic areas. It emerges that nurses are generally uncertain about their role and tend to lapse into traditional practices and 'do for' the patient rather than promote independence. This is reinforced by the routine organisation of work, *e.g.* early morning dressing where the pressure is to 'get things done'. Furthermore the 'carry on' role is compromised by the fact that nurses often lack the requisite knowledge both to assess progress and to maintain the skills of the patient in dressing and mobilising. Compounding this is the failure to acknowledge the potential role overlap between therapists, with channels of communication being poorly developed. Possibly the most disturbing of Waters' conclusions (one reinforced in other studies unrelated to rehabilitation) is that even within the 'specialist' areas of continence promotion and skin care, nurses often treat these as a set of practical tasks and appear unaware of, or do not apply, a coherent assessment framework. Waters is rightly cautious about generalising from her small-scale study but, as she points out, a considerable gerontological literature over 30 years reinforces her overall conclusions.

In stark contrast to this bleak picture is Sheppard's (1994*a*) description of a nursing development unit dedicated to the rehabilitation of older people. This action research study produced many insights into the effort and determination required to establish a more holistic and individualised approach to rehabilitation. Central to the unit's success was the inclusion of the patient and his or her family as active participants in the rehabilitation process, together with a nursing role which was primarily concerned with the phased withdrawal of physical support whilst simultaneously paying increased attention to emotional and psychological components. Implementing these principles did not prove to be easy, however, and several barriers had to be overcome, including the need to convince patients that nurses should not be doing things for them. This required the creation of explicit mechanisms, such as a patients' forum, to facilitate active patient involvement. Sheppard details how such challenges were by and large successfully addressed and, although not a nurse herself, she presents an optimistic picture of rehabilitation nursing as a complex area of practice.

Possibly one of the greatest challenges to more active nursing input is posed by the largely invisible and subtle nursing role described by Sheppard. This may struggle to gain acceptance in a health care world which is increasingly dominated by quantifiable outcome measurement

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

and is methodologically wed to the 'randomised controlled trail'. Such an orientation ignores questions about the appropriateness of relatively crude outcome measures (such as morbidity and mortality) and their use as a proxy for successful rehabilitation. This is a debate to which nursing can make a potentially valuable contribution. To do so there is however a need for greater specificity both in determining more sensitive outcome measures and how nurses can contribute to their achievement.

The fundamental problem is the failure to clarify and define the nurse's role in rehabilitation and its 'invisibility' in the wider literature. Although some authors describe nurses as 'rehabilitators *par excellence*' (Sheppard 1994*b*), and others praise their contribution to specific areas of rehabilitation such as re-activation, re-socialisation and re-integration (Jackson 1984), these positive traits are not reinforced in nursing and medical texts (Sheppard 1994*a*, Waters 1996). The framework suggested by Jackson (1984) offers considerable promise but has never been fully elaborated or operationalised. Sheppard concludes that 'nursing and nurses are notable in the literature about rehabilitation by their virtual absence'. Walker (1995) noted that nurses are unable to define their role in rehabilitation and, as she and others have suggested, see this practice as largely in the domain of the therapy disciplines, particularly physiotherapists (Johnson 1995, Walker 1995, Waters and Luker 1996).

This reflects the currently dominant view of rehabilitation as principally a physical process, with restoration of function being the ultimate aim (Beardshaw 1988, Waters 1991, 1996, Waters and Luker 1996, Sheppard 1994*a*). Consequently rehabilitative effort is focused primarily on the acute phase of illness and disability (Gibbon and Thompson 1992) within a hospital setting (Waters 1987, 1991, Waters and Luker 1996, Walker 1995). Moreover, the educational preparation of nurses pays scant regard to rehabilitation generally (Waters 1987, 1991, 1996, Gibbon and Thompson 1992, Sheppard 1994*a*) and is concerned mainly with acute care. Commentators other than nurses have noted the lack of attention given to chronic illness and suggest that this may account for the manifest failure of nursing to meet the needs of disabled people both when they enter hospital (Beardshaw 1988) and in their own homes (Baker *et al.* 1997). In this light, it is perhaps not surprising that nurses are generally accorded a secondary role in rehabilitation (Waters 1991, 1996, Gibbon and Thompson 1992, Johnson 1995). Their role is seen as comprised of specific components and is underpinned by several assumptions, including:

- The maintenance of the physical well-being of patients by attention

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

to basic care needs, *e.g.* skin, nutrition and hygiene (Andrews 1987, Waters 1987, 1991, 1996, Johnson 1995). This is characterised by Johnson (1995) as ensuring that patients are clean, comfortable and ready for therapy.

- A specialist role in areas such as continence promotion and care of the skin (Waters 1991, 1996).
- Creating and sustaining a suitable environment for rehabilitation (Jackson 1987, Waters 1987, 1991, 1996, Sheppard 1994*a*) which facilitates the identification of patients' motivations, hopes and aspirations and their active participation in rehabilitation. Despite this stated intention, patients are largely passive recipients of rehabilitation (Waters 1987, 1991, 1996).
- Reinforcing the input of others, mainly therapists (Waters 1991, 1996, Waters and Luker 1996, Sheppard 1994*a*, Gibbon and Thompson 1992, Johnson 1995, Squires 1996). For example Johnson (1995) sees nurses as providing the 'glue or mortar' that holds the bricks (*i.e.* therapy input) together.
- A 24 hour presence is often portrayed as nursing's unique contribution (Andrews 1987, Waters 1987, 1991, 1996, Sheppard 1994*a*), but it seems pertinent to ask what nurses *do* during this period.

On the basis of the available literature, the current nursing role in rehabilitation is narrowly construed and does not reflect the more holistic model suggested by Sheppard and others. Waters (1996) argues that the nurses' role in rehabilitation is, or at least should be, multifaceted and that what makes it unique is not its components but their combination. She suggests that the current emphasis on primary care provides an opportunity to reconceptualise rehabilitation and for nursing to realise its full potential. Other nursing authors paint a more 'traditional' picture in which the primary emphasis is placed on the prevention of deterioration and the restoration of functioning (Gale and Gaylard 1996). Whilst this will certainly remain a central part of the nurse's role, the wider focus described by Sheppard (1994*a*) seems slow to permeate professional ambitions.

Given the importance of teamwork in rehabilitation (Waters 1991, 1996), it is clearly insufficient for nursing to act independently. There is a need for the functional model of health currently prevalent in rehabilitation (Wilkin and Hughes 1986, Mulley 1994) to be complemented by other approaches which recognise the continuing needs of many disabled people. One such model is described by Robinson (1988), who contrasts a short-term orientation with long-term goals (Table 1). He argues that the long-term model is more

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

TABLE 1. *Rehabilitation models*

Short-term	Long-term
Focus on impairment/disability	Focus on handicap
Technique-orientated	Patient-orientated
Doctor as controller	Doctor as co-ordinator
Therapist as agent	Therapist as autonomous
Hospital based	Community based

TABLE 2. *Contrasting models for health care*

Criteria	Simple Acute Disease Model	Chronic Complex Illness Model
Cause	Single agent sufficient	Multiple contributing factors
Basis of disease	Altered physiology (Biologic)	Biopsychosocial
Aim of interventions	Normal physiology (cure)	Ameliorate and relieve suffering
Temporal relationship	Single event	Continuous process
Role of patient	Passive recipient	Active participant

appropriate to rehabilitation but that its implementation is hindered by professional rivalry. Robinson (1988) believes that therapists form the ideal bridge linking the two models and the role of nursing is hardly considered. More recently, Pawlson (1994) calls for a 'new paradigm' of health care which is more relevant to the needs of modern society, and he advocates the adoption of a 'chronic complex illness model' which he contrasts on several criteria with the currently prevalent 'acute simple disease model' (Table 2). In terms of rehabilitation, Pawlson (1994) argues that the 'Chronic complex illness' model is more appropriate, but that it is the simple acute approach that is usually applied. He suggests that the patient must be the key decision-maker in rehabilitation and sees this as being the primary indicator of a quality service. Reflecting such sentiments, Price (1996) calls for 'recognition that the definitions of chronic illness, quality of life and comfort are legitimately the preserve of patients'. In identifying common elements to aid nursing assessment, he lists a number of recurrent themes in the literature, *viz*: dealing with uncertainty; reconstructing self; managing regimes; managing relationships and a number of concepts related to the 'altered' body. Other nursing authors have recently taken a similar stance.

The need to re-orientate practice away from illness and disability towards health and wellness is now clearly recognised (RCN 1994). In

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

operationalising this approach, Lindsey (1996) outlines a model of 'health within illness' gained from her empirical data which comprises six themes:

- Honouring self and respecting who you are;
- Maintaining relationships and reciprocity;
- Seeing illness as presenting a challenge and opportunity;
- Transcending the illness;
- Celebrating a life with illness, a process which reinforces the value of being alive;
- Recognising the spiritual aspects of illness.

Lindsey (1996) believes that nurses have a key role to play in facilitating achievement of these aims but argues that there is a need for a 'fundamental transformation in their philosophical perspective' which moves nursing care beyond a simple problem solving framework. Lindsey's stance reinforces the important of the interpersonal dynamic in rehabilitation nursing, in particular the need for nurses to appreciate and value patients' subjective experiences. Lamb and Stempel (1994) see the formation of a long-term relationship as essential and contend that a significant nursing task is to assist patients to become 'insider experts', capable of being their own care managers.

Based on their empirical work they describe three inter-related and hierarchical components which they see as central to positive adaptation: affective, cognitive, and behavioural. The affective element is a prerequisite for the subsequent stages and involves establishing a bond of trust between nurse and patient. This cannot be achieved until the patient is satisfied that the nurse knows and understands them as an individual. The second element is termed 'working' and concerns a cognitive shift in perception towards redefinition of the self as complete and valuable. Only then can the behavioural element 'changing' be considered. Here the patient is both able to help his or herself whilst simultaneously accepting help from others. Therefore in addition to their technical expertise, Lamb and Stempel (1994) describe other nursing roles including: monitoring; co-ordinating; teaching and enabling. To progress, nursing must recognise a role in rehabilitation which extends beyond physical care. However, some recent debates remain dominated by such an orientation. For example, Gale and Gaylard (1996) recognise the fundamental role of nursing in restoring health but then proceed to the following description of rehabilitation:

> Assisting patients to overcome their handicaps, by helping them to return function to a part of the body or by optimising the use of remaining abilities, is the essence of rehabilitation … the underlying philosophy of contemporary nursing is that care is based on planning and using skills that prevent

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

deterioration or restore physical function immediately the patient is admitted to the ward or referred to the community team. Some have termed this rehabilitative nursing care (Gale and Gaylard 1996, p. 144).

Although the prevention of deterioration and the restoration of physical functioning is a key component of rehabilitative nursing it cannot provide a complete definition. A logical extension of the above definition is a return to the nursing role in rehabilitation as described by Andrews (1987), a physician:

> Others have suggested that nurses could take on the basic rehabilitation work, thereby leaving the trained therapists free to carry out highly specialised rehabilitation techniques. Nurses are in a particularly suitable position to take on the general rehabilitation training of patients since they are responsible for the management of patients throughout the 24 hour period and spend more time with patients than any other professional group (Andrews 1987, p. 15).

It is hard to argue with many of the sentiments above as nurses *do* spend more time with patients than any other formal providers. However, this time can better be utilised to address not only 'basic rehabilitation work' but also the affective, cognitive, biographical and existential aspects of care which are consistently identified as an essential component of a comprehensive approach to rehabilitation, but which are so often absent. The conceptualisation of the nursing role presented by Waters (1996) in the form of a matrix with general maintenance, specialist and 'carry on' roles along one axis and patient education, health promotion, tissue viability, continence, dressing, mobility and personal hygiene along another reflects a more holistic approach but perhaps fails fully to capture the subtle dimensions of the role she advocates. There is now widespread recognition that nurses provide a multi-faceted contribution to the rehabilitation process, with an educative role being one of the most frequently cited. Indeed many see this as being the single most important nursing contribution to rehabilitation: it is recognised that education must extend beyond giving information to help patients to re-integrate their lives (Coates and Boore 1995). In addition to the physical components of care and the above instructional and educative elements, a range of other nursing roles such as monitoring, coordinating and enabling (Lamb and Stempel 1994) and counsellor, collaborator, communicator and manager (Brillhart and Sills 1994) have been described.

If nursing has a serious intent to make a major contribution to rehabilitation that transcends general maintenance, a few specialist functions (continence, skin integrity) and a 'carry on' role, then the profession must begin to articulate what this is. This means bringing a

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

greater precision to bear. If the nurse is an enabler, *what* is being enabled? If the nurse is a co-ordinator or organiser, who or what is being organised and co-ordinated and are they even aware of it? Many of the difficulties inherent in teamwork are due to the failure to understand the roles of other team members. Overcoming this requires greater role clarification so that various contributions can be shared, debated and at least acknowledged, even if a consensus proves elusive. Furthermore, it is not possible to provide an appropriate educational preparation based on the level of generality apparent in much of the debate about the nurse's role in rehabilitation.

Rehabilitation: a broader perspective

It is suggested that nurses, rather than therapists, as Robinson (1988) argues, are in the ideal position to build a bridge between short-term and long-term rehabilitation and to marry the objective with the subjective. Certainly there is presently a hiatus and the present flux in the health services provides the ideal opportunity to fill it. Nursing therefore may wish to be pro-active and seize this opportunity not simply because it is expedient and opportune, but rather because nursing as a profession is best placed to do so. As Beardshaw (1988) noted, what is lacking is a coherent and organised framework to address the needs of chronically ill and disabled people (Baker *et al.* 1997). It can be argued that of all professional groups, nursing is the one with potential input at all stages of illness. Hoeman (1996) contends that rehabilitation nursing is concerned with life-long care transitions and that it spans primary prevention, acute, sub-acute and tertiary care. This means that the focus and scope of rehabilitation has to be extended beyond the current limited conceptualisation to incorporate interventions addressing the bio-psychosocial impact of illness and disability in all care settings including the patient's home and nursing homes.

Realising Hoeman's vision is not however straightforward, for whilst there are multiplying theories on which nurses and others might draw, considerable resistance is likely to be encountered, particularly from medical colleagues. To the extent that rehabilitation has been perceived as a specialist area of practice at all in Britain, it has largely been the preserve of the therapy disciplines but the situation is changing. There are now standards of practice for rehabilitation nurses (RCN 1994) and rehabilitation medicine is also laying claim to specialty status

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

(Vaughan and Bhakatu 1995). This is a development which nursing should heed. There is clearly a need to work as closely as possible with medical and other colleagues but history cautions that when medicine plays a significant role in any development, it is likely to be the dominant influence. The evolution of both geriatric medicine and geriatric nursing provides a telling case and the parallels between this and the current position in respect of rehabilitation are striking.

Geriatric medicine emerged largely as a response to the therapeutic nihilism that existed regarding the care of older people in the late 1940s and early 1950s. The introduction of more holistic treatment modalities revolutionised the care older people received and many were successfully discharged from long-stay hospitals. However, as geriatric medicine struggled to gain acceptance from its more prestigious peers in medicine and surgery, its early holistic orientation was replaced with a more pragmatic and readily observable criterion of success. Wilkin and Hughes (1986) argue that geriatric medicine, being unable to cure most of the diseases of old age yet required to achieve a through-put of patients, substituted a functional model of health for the more traditional medical model. Once again the parallels with current rehabilitation are clear. If rehabilitation medicine flourishes, the push towards ever more observable and measurable outcomes is likely to accelerate.

Rehabilitation nursing has aspirations towards a more holistic approach which stresses health and wellness rather than disability and illness. Roles such as facilitator and enabler are espoused, but exactly what is to be facilitated or enabled is often not made clear. This is insufficient and nursing is unlikely to develop if its contribution is not made explicit. As Wells (1980) noted, 'the problem in geriatric nursing is the problem in all nursing, nurses do not know why they do what they do.' It is time for gerontological nursing to transcend rhetoric and to advance the rehabilitation of older people to the status that it merits. This will mean identifying what the nursing contribution is, articulating this clearly and demonstrating its effectiveness using criteria which move beyond readily observable functional gains and tap more actively into patient and carer perceptions of success. This does not mean, as Oliver (1993) notes,'throwing the baby out with the bath water', as a functional model of rehabilitation is relevant and appropriate in many instances. On the other hand, for increasing numbers of frail older people an alternative is needed which recognises their need for on-going support across a range of care environments. This, as Norton (1965) suggested, constitutes 'true nursing' and should become a professional priority.

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

References

Andrews, K. 1987. *Rehabilitation of Older Adults*. Edward Arnold, London.
Armstrong-Esther, C. A., Browne, K. D. and McAfee, J. G. 1994. Elderly patients; still clean and sitting quietly. *Journal of Advanced Nursing*, **19**, 264–271.
Baker, M., Fardell, J. and Jones, B. 1997. *Disability and Rehabilitation: Survey of Education Needs of Health and Social Service Professionals: The Case for Action*. Disability and Rehabilitation, Open Learning Project, London.
Beardshaw, V. 1988. *Last in the List: Community Services for People with Physical Disabilities*. King's Fund Institute, London.
Brillhart, B. and Sills, F. 1994. Analysis of roles and responsibilities of rehabilitation nursing staff. *Rehabilitation Nursing*, **19**(3), 145–150.
Coates, V. E. and Boore, J. R. P. 1995. Self management of chronic illness and implications for nursing. *International Journal of Nursing Studies*, **32**(6), 628–640.
Evers, H. K. 1991. Care of the elderly sick in the UK. In S. J. Redfern (ed), *Nursing Elderly People*, Churchill Livingstone, Edinburgh, 417–436.
Funk, S. G., Tornquist, E. M., Champagne, M. T. and Wiese, R. A. 1993. *Key Aspects of Caring for the Chronically Ill*. Springer, New York.
Gale, G. and Gaylard, J. 1996. The role of the nurse in rehabilitation of older people. In Squires, A. J. (ed), *Rehabilitation of Older People: A Handbook for the Multidisciplinary Team*, 2nd Edition, Chapman and Hall, London, 144–166.
Gibbon, B. and Thompson, A. 1992. The role of the nurse in rehabilitation. *Nursing Standard*, **6**(36), 32–35.
Henderson, V. Citation in Sheppard, B. 1994. *Looking Back – Moving Forward: Developing Elderly Care Rehabilitation and the Nurse's Role Within It*. Brighton Health Care NHS Trust, Brighton, Sussex.
Hoeman, S. P. 1996. *Rehabilitation Nursing: Process and Application*, 2nd Edition, Mosby, St Louis, Missouri.
Jackson, M. F. 1984. Geriatric rehabilitation on an acute care medical unit. *Journal of Advanced Nursing*, **5**, 441–448.
Jackson, O. S. 1987. Basic principles in rehabilitation. *Clinical Physical Therapy*, **14**, 1–22.
Johnson, J. 1995. Achieving effective rehabilitation outcomes: does the nurse have a role? *British Journal of Therapy and Rehabilitation*, **2**(3), 113–118.
Lamb, G. S. and Stempel, J. E. 1994. Nurse case management from the client's view: growing as insider-expert. *Nursing Outlook*, **42**, 7–13.
Lindsey, E. 1996. Health within illness: experiences of chronically ill/disabled people. *Journal of Advanced Nursing*, **24**(3), 465–472.
Mulley, G. P. 1994. Principles of rehabilitation. *Reviews in Clinical Gerontology*, **4**, 61–69.
Nolan, M. R. 1994. Geriatric nursing: an idea whose time has gone? A polemic. *Journal of Advanced Nursing*, **20**, 989–996.
Nolan, M. R. 1996. Developing a knowledge base in gerontological nursing: a critical appraisal. In Wade, L. and Waters, K. (eds), *A Textbook of Gerontological Nursing*. Baillière Tindall, London, 210–237.
Norton, D., McClaren, R. and Exton-Smith, A. N. 1962, reprinted in 1979. *An Investigation of Geriatric Nursing Problems in Hospital*. Churchill Livingstone, Edinburgh.
Norton, D. 1965. Nursing in geriatrics. *Gerontologia Clinica*, **7**, 57–60.
Nursing Times 1996. Elderly care counts, *Nursing Times* Campaign.
Oliver, M. 1993. A different viewpoint – who needs rehabilitating? In Greenwood, R., Barnes, M. P., McMillan, T. M. and Ward, C. D. (eds), *Neurological Rehabilitation*, Churchill Livingstone, Edinburgh, 38–39.
Pawlson, L. G. 1994. Health care reform. Chronic illness – implications of a new

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press

paradigm for health care. *Joint Commission Journal on Quality Improvement*, **20**(1), 33–39.
Price, B. 1996. Illness careers: the chronic illness experience. *Journal of Advanced Nursing*, **24**(2), 275–279.
Reed, J. and Watson, D. 1994. The impact of the medical model on nursing practice and assessment. *International Journal of Nursing Studies*, **31**(1), 57–66.
Rempusheski, V. F. 1991. Historical and futuristic perspectives on aging and the gerontological nurse. In E. M. Baines (ed), Perspectives in Gerontological Nursing, Sage, Newbury Park, California, 3–28.
Robinson, I. 1988. The rehabilitation of patients with long term physical impairments: the social control of professional roles. *Clinical Rehabilitation*, **2**, 339–347.
Royal College of Nursing 1993. *The Value and Skill of Nurses Working with Older People*. Royal College of Nursing, London.
Royal College of Nursing 1994. *Standards of Care: Rehabilitation Nursing*. Rehabilitation Nurses Forum Committee, RCN, London.
Sheppard, B. 1994. *Listening to Patients: An Action Research Project*. Brighton Health Care NHS Trust, Brighton, Sussex.
Squires, A. J. 1996. (ed), *Rehabilitation of Older People: A Handbook for the Multidisciplinary Team*, 2nd Edition, Chapman and Hall, London.
Vaughan, C. and Bhakta, B. 1995. Recent advances in rehabilitation medicine. *Journal of the Royal College of Physicians of London*, **29**(6), 534–539.
Wade, L. 1996. New perspectives on gerontological nursing. In Wade, L. and Waters, K. (eds), *A Textbook of Gerontological Nursing: Perspectives on Practice*. Baillière Tindall, London, 3–26.
Wade, L. and Waters, K. 1996 (eds), *A Textbook of Gerontological Nursing: Perspectives on Practice*. Baillière Tindall, London.
Walker, G. 1995. Therapists and nurses in older people's rehabilitation: unmet role performance expectations. *British Journal of Therapy and Rehabilitation*, **2**(1), 9–12.
Waters, K. 1987. The role of nursing in rehabilitation care. *Science and Practice*, **5**(3), 17–21.
Waters, K. 1991. The role of the nurse in rehabilitation of elderly people in hospital. Unpublished PhD Thesis, University of Manchester, Manchester.
Waters, K. 1996. Rehabilitation. In Wade, L. and Waters, K. (eds), *A Textbook of Gerontological Nursing: Perspectives on Practice*. Baillière Tindall, London, 238–257.
Waters, K. and Luker, K. A. 1996. Staff perspectives on the role of the nurse in rehabilitation wards for elderly people. *Journal of Clinical Nursing*, **5**(2), 103–114.
Wells, T. J. 1980. *Problems in Geriatric Nursing*. Churchill Livingstone, Edinburgh.
Wilkin, D. and Hughes, B. 1986. The elderly and the health services. In Phillipson, C. and Walker, A. (eds), *Ageing and Social Policy*. Gower, Aldershot, Hampshire, 163–183.

https://doi.org/10.1017/S0144686X97006545 Published online by Cambridge University Press